SATURDAY, FEBRUARY 15, 1873.

ORIGINAL LECTURES.

LECTURES

ON THE SURGERY OF THE NARES, LARYNX, AND TRACHEA.

BEING THE MÜTTER LECTURES FOR 1872.

Delivered before the College of Physicians of Philadelphia,

BY J. SOLIS COHEN, M.D.

Reported by R. M. BERTOLET, M.D.

(Continued from page 292.)

LECTURE III.

ACUTE LARYNGITIS.

ACUTE laryngitis, catarrhal laryngitis, or erythematous laryngitis, is an inflammation of the mucous membrane, sudden and severe in its onset, and generally of short duration. It often occurs as an idiopathic affection, brought on by sudden or unusual exposure to cold, especially in the feeble and convalescent individual; but it is much more frequently met with in the course of chronic tuberculous or syphilitic laryngitis, an acute laryngitis being superimposed upon the pre-existing chronic affection. It also occurs in typhus fever, in pyæmic fever, and in erysipelas. It may be induced by overstraining the voice, or by inhalation of irritant vapors, etc. The presence of a foreign body in the pharynx may give rise to it, or the incautious use of instruments within the cavity of the throat, whether for the purpose of diagnosis or for the extraction of foreign bodies. Sometimes it has followed the use of the epiglottic forceps; sometimes it has been induced by severe cauterization of the larynx, or even of the pharynx. The most frequent cause of acute laryngitis is of traumatic origin, such as the partial deglutition of caustic solutions or boiling water, the inhalation of steam, flame, or acrid substances; the inflammation of the larynx supervening immediately.

Acute laryngitis, if at all severe, is generally ushered in by a chill, followed by fever; sore throat being also one of the earliest symptoms. The pain in the larynx is severe, very often described as scratching or burning, and is usually increased for the time by coughing, protracted or loud speaking, or the access of cold air to the parts: with this there is tenderness upon pressure, and there is a feeling of constriction as though there were a foreign body within the larynx. There is reason to believe that this sense of constriction is occasionally due to a spasmodic condition of the adductor muscles of the glottis on the one hand, or to a paralyzed condition of its dilator muscles on the other. Dyspnœa and dysphagia are speedily manifested. The voice generally becomes hoarse, and its emission is often difficult and painful; the words being frequently interrupted by wheezing and prolonged efforts of inspiration, symptoms which are indicative of constriction, whether from spasm or mechanical impediment situated above the glottis. Sometimes there is paresis of the vocal cords, usually with complete patency of the entire glottis, due to the extension of the inflammation to the constrictor muscles; and then there is more or less dysphonia, or even aphonia, in consequence. The cough is hoarse, hollow, or brassy, like that of croup, and is generally accompanied by a slight expectoration of mucus. As the disease advances, the fever grows more intense, the severity of the local symptoms increases, the appearance of the patient is anxious, suffocative paroxysms of dyspnœa and of spasm of the glottis ensue, the face becomes cyanotic, and, unless speedy relief is afforded, death occurs from gradual suffocation and coma, or from veritable asphyxia. Although the actual amount of inflammatory action present may not be very great, yet the conformation of the parts involved is such that even a moderate amount of swelling of the mucous membrane of the larynx will often seriously interfere with the respiratory function; and it is this mechanical impediment to free respiration that constitutes the grave and serious lesion of this disease.

As a usual thing, the inflammation involves the entire larynx, but very often it is confined to its upper portion; sometimes it is restricted to some special locality, as the epiglottis, one or both ventricular bands, one or both vocal cords, one or both arytenoids, etc.; and occasionally there are seen points of erosion along the crest of the epiglottis, or even upon its laryngeal face, or upon the Santorinian eminences, or upon the vocal cords; but these manifestations are uncommon.

The secretion of mucus is generally slight in quantity, and is usually of a serous quality, viscid but thin. In some cases the secretion is quite viscid and adherent, and is expectorated with difficulty in small pellets, while in other cases there is no evidence of abnormal secretion. Sometimes the irritation extends along the mucous membrane of the trachea and bronchi, and we have the evidences of inflammation of these structures superadded to the special phenomena of laryngitis.

Acute laryngitis may be conveniently separated into two forms; one in which the inflammation is limited to the mucous membrane, and the other in which it extends into the sub-mucous connective tissue.

In the first form of laryngitis, the entire laryngeal mucous membrane is very red and very much infiltrated. The epiglottis is swollen out to three or four times its normal bulk, while the mucous membrane of the ary-epiglottic folds, Santorinian and arytenoid cartilages, and ventricular bands, and sometimes even that of the vocal cords, is similarly swollen; the swelling being either symmetrical, or limited to one side only. This swelling is sometimes so extensive as to leave only a very narrow passage for the air; it greatly impairs the motion of the parts, so that the glottis can no longer be fully dilated, and a speedy termination of the patient's life by suffocation is threatened.

The disease, unless fatal, continues from seven to

ten days; there are, however, cases recorded in which its entire course was run in less than twenty-four hours. In mild cases of this disease the acute phenomena of fever will be absent; there is little or no impediment to respiration and deglutition, but the pain is severe and the voice hoarse. Upon examination the laryngeal mucous membrane will be found to be congested and of a fiery red color.

A subacute laryngitis accompanies many cases of bronchitis, and not infrequently attends pulmonary phthisis and other affections of the lungs. Another variety of this form is one which involves the trachea to a greater or less extent,—properly a laryngo-tracheitis. This may be simply catarrhal; or it may be pseudo-membranous, under which circumstances it is known as croup.

In the second form of acute laryngitis we have greater swelling than in the preceding form, from serous infiltration into the sub-mucous connective tissue, and we have the symptoms and appearances of œdema of the larynx. The severity of the local phenomena does not bear any relation to the amount of the febrile derangement, which is much less than in laryngitis which is confined to the mucous membrane. On the other hand, the local symptoms are much more severe, and more imperatively require immediate relief.

In the treatment of acute laryngitis it is essential to arrive at a proper diagnosis at an early date, and to act promptly and efficiently, remembering that it is an acute affection, rendered more dangerous on account of the locality invaded than from the violence of its action, and that, for this reason, local treatment must take precedence of general. Here the laryngoscope will be found of the greatest service, both as a means of accurate diagnosis, and for the successful application of local measures.

General and local depletory measures are not applicable here as in inflammations elsewhere, because we dare not always wait for their action. In the milder cases, the external application of leeches, the use of salines, and the inhalation of atomized astringent solutions, such as alum or sulphate of zinc, will prove beneficial, with perfect rest of the organ and maintenance of an equable temperature. The use of warm drinks or other methods of inducing moderate diaphoresis may sometimes be advantageously seconded by the frequent exhibition of small doses of aconite. If the pain in the parts is severe, the watery extract of opium, or a small quantity of morphia, should be added to the inhalation; and if there is considerable disturbance of the nervous system, anodynes in efficient doses should be administered, by enema or hypodermically. Gibb and others recommend the local use of strong solutions of nitrate of silver or sulphate of zinc; but the lecturer had never seen the necessity for such treatment. In severer cases, especially where there is œdema, early scarification of the parts, or sometimes mere puncture, will be of immense service.

Where scarification cannot be resorted to, tracheotomy should be promptly performed, that the lungs may receive a due supply of air to enable the system to pass through the natural stages of the inflammatory process. This operation should be performed the very moment that the impediment to respiration becomes serious. If the opening of the trachea be postponed, the blood will become so thoroughly poisoned by carbonization that the patient will succumb in a few hours after having been relieved of the local symptoms, or he may linger on for a few days, relieved from the immediate dyspnœa, and perish ultimately from the effects of the congestion of the lungs or brain which has followed the prolonged difficulty of respiration.

Acute laryngitis usually subsides without leaving any traces of its presence. Sometimes, however, it declines into a chronic laryngitis, which in many instances is apt to prove ulcerative; occasionally it is the direct precursor of the formation of morbid growths within the larynx. At times, too, it is followed by paralysis of the vocal cords. In acute laryngitis of traumatic origin there is an element of complication, from the destruction of tissue which is produced by the accident. Ulceration of the mucous membrane itself does not often take place in idiopathic laryngitis. The cartilages are rarely affected in acute laryngitis. Laryngoscopic inspection occasionally shows that the seat of the inflammation is limited to special portions of the larynx, without any active participation of the adjacent structures. The terms epiglottitis, chorditis vocalis, arytenoiditis, meso-arytenoiditis, are often employed to designate the particular seat of the inflammation. These lesions are to be treated in the same manner as acute laryngitis of a mild type affecting the entire organ; but if great swelling or œdema is present, scarification is required.

A subacute catarrhal laryngitis sometimes protracts convalescence after the severe symptoms of the acute form have passed away: this is to be treated by repeated applications of moderately strong (20 grs. to ℥j) solutions of nitrate of silver or sulphate of copper, assisted, if need for it appear, by the internal or external use of iodine or of mercury.

ACUTE LARYNGITIS IN CHILDREN.

Acute laryngitis in children, even where the inflammatory processes are confined to the mucous membrane, is apt to be more severe than in the adult. This is in part due to the greater sensitiveness and delicacy of the parts themselves, but also doubtless, in a great measure, on account of the greater sensitiveness and greater excitability of the nervous system in children. Thus the phenomena of spasm, whether they be direct or reflex, are more severe in themselves, and, on account of the small size of the larynx, more dangerous in their results. The condition to be described, though in its local manifestations it has much in common with laryngismus stridulus, is to be discriminated from that affection, which is more closely a neurosis, and unattended with the phenomena of inflammation which characterize a veritable laryngitis.

The affection is sometimes ushered in suddenly; though there is reason to believe that some general or special cause has given origin to it, which is either concealed or has not attracted attention. In other

cases it is preceded by the phenomena of coryza, pharyngitis, or bronchitis, the symptoms of which may have been so trifling as to have caused no anxiety on the part of the nurse or parent.

Like laryngismus stridulus, and like croup, the phenomena of paroxysmal cough, with impeded, noisy, or stridulous respiration, which first excite alarm, occur at night, and frequently rouse the patient from sleep. During the paroxysms the face becomes flushed, the pulse accelerated, and the motions of the child exhibit restlessness or anxiety. After a period, variable in its duration, these phenomena subside, and the patient falls asleep. A recurrence of the attack may take place during the night, or not until the next day or the next night. In the interval there are symptoms of moderate febrile reaction; the respiration is free, but more or less sonorous; the voice is more or less hoarse, the cough more or less harsh and dry. Sometimes there is slight disturbance of the digestive organs, but usually the general health does not appear to suffer. In a few days the phenomena gradually subside, respiration becomes quieter, the cough less harsh and more moist, and the voice gradually regains its ordinary quality of tone. Sometimes the phenomena of spasm are slight or entirely wanting, and the febrile condition may be so slight as to give no evidence of its existence; at other times the spasmodic phenomena are excessive, and may threaten asphyxia, and the febrile reaction is very great.

Moderate general antiphlogistic treatment is usually sufficient to subdue the acute laryngitis of children, care being taken by due administration of nutriment, and, if necessary, by tonics or even alcoholic preparations, to keep up the strength of the patient as far as possible. The relaxing influence of the warm bath, and the inhalation of the steam from hot water, may often be resorted to with advantage.

There is no disposition here to the exudation of false membrane, and therefore no permanent impediment to respiration. Should, however, œdematous effusion take place, the existence of which can almost always be detected by a digital exploration, or should the element of spasm be so pronounced as to threaten suffocation, the operation of tracheotomy becomes necessary, as in the adult; though in the case of serous œdema the effusion could sometimes be discharged by rupturing the distended membrane with the finger-nail. Laryngoscopic examination in these cases is practicable only as the exception, and not as the rule.

(To be continued.)

CLINICAL LECTURE ON CHRONIC MYELITIS.

BY DR. H. C. WOOD, JR.

Delivered at the Philadelphia Hospital.

Reported by Dr. W. H. PARISH, Resident Physician.

GENTLEMEN,—Pathologically speaking, there are but two, or at most three, ordinary diseases of the substance proper of the spinal cord. Let us consider for a moment the anatomy of this nervous centre. We have the nerve-cells and nerve-tubules, and the trabeculæ or the fibrous tissue,—an arrangement somewhat analogous to that of hepatic cells and connective tissue. Of course in the spinal cord there are also blood-vessels and probably lymphatics. Each chronic disease is situated in the nerve-cells and tubules or in the connective tissue; the latter tissue being only a modification of that seen throughout the system. Under the microscope it presents a granular condition after having been hardened with alcohol or chromic acid, but during life is most probably largely an amorphous material, with nuclei and some cells,—the granulations seen in the ordinary preparations being produced by the reagents used for hardening. Two of the chronic diseases of the cord are inflammatory; one of these is an inflammation of the connective tissue, known as sclerosis of the spinal cord, and analogous to cirrhosis of the liver. In this the nuclei of the connective-tissue cells increase in number, the cells multiply by division, and thus, the neuroglia becoming increased in quantity, a pressure is produced upon the nerve-cells and nerve-tubules. The result of this pressure is the gradual atrophy of these nerve-structures. Moreover, there is an exudation into or around the walls of the blood-vessels, and, like exudative or cicatricial tissue, everywhere this exudation gradually contracts, and thus by degrees produces an obliteration of the blood-vessels.

The other form of inflammatory change results in spots or foci of softening, disseminated along the cord-substance. These spots vary in color from a reddish to a pale yellow, the colors being due to extravasation of blood, and their varying hues dependent upon the date of the extravasation. A microscopical examination of these spots shows us fatty, broken-down nerve-tubules and some nerve-cells which have undergone the same change. We also see a multiplication and a granular condition of the connective-tissue cells. There are also seen a large quantity of granular bodies, and sometimes pus-cells. The walls of the blood-vessels are also seen to be fatty. This process then is one of inflammatory softening; the softening varying with the stage of the process. The disease is gradual but steady in its course, and may last for years.

The third form of chronic spinal disease is not one of inflammation, but is a form of simple fatty degeneration, or what is generally known as "white softening."

If the anterior and lateral columns of the cord are the principal seat of either of these lesions, the motor functions are chiefly perturbed, and paralysis more or less complete, with or without other symptoms, results. An involvement of the posterior column would interfere with the functions of sensation. A diminution of sensation, wandering pains, and loss of muscular co-ordination are symptoms which go to make up locomotor ataxia,—a spinal disease, whose clinical history is characteristic, yet the pathology of which is simply that of sclerosis involving the posterior column. It is doubtful if the cause of chorea and paralysis agitans is to be looked for in any lesion of the spinal cord. Of course we have tumors, traumatic injuries, etc., more or less

destructive to the cord; but we cannot now speak of these.

To-day we have before us two patients apparently representing the two inflammatory chronic diseases of the cord. The one of whom we shall first speak is

Charles D., æt. 36 years, a native of Germany, by occupation a machinist; of temperate habits; not addicted to excessive venery, and with no syphilitic taint. The following history up to the date of his admission we gather from his own statements:

His father, brothers, and sisters were quite healthy. His mother, however, was of a nervous temperament, and was subject to attacks which seem to have been epilepsy or hysteria. His father's occupation was that of a manufacturer of leaden pipes, copper and brass utensils, etc. The patient never worked in the shop, but, as salesman, handled the different articles. At the age of twenty-one he left his father's employ and came to America. Here for a while he did work in a paint-factory, but, being seized with some nervous disorder, which, however, lasted but a few days, he entered a boiler-factory, where he worked on copper boilers for a few years. Afterwards he was employed to polish axes, in which process fine copper dust was used.

When about nineteen years of age, he was first attacked with abdominal cramps. These continued about two weeks, when they in a great measure disappeared. Then supervened muscular contractions, especially of the lower extremities. So forcible were these contractions that it required the strength of two men to hold the patient in bed. When unrestrained, his body would be jerked up one or two feet from the mattress. Throughout this attack the bowels were usually constipated. On only one occasion does there seem to have been loss of consciousness, and then for a few minutes only. He was restored to health in about three months, afterwards doing service in the Prussian army.

During the latter part of 1869, while in the St. Mary's Hospital, and convalescent from typhoid fever, there came on an attack apparently very similar to the present one, which disappeared in about eight months. After leaving that hospital he again entered a boiler-factory. During January of the present year (1872) he was in the Municipal Hospital with an attack of variola. On February 10, 1872, after being a few days out of the Municipal Hospital, he was admitted to this hospital suffering with acute laryngitis and albuminuria. The laryngitis was severe and quite obstinate. Constipation also existed. On April 1 the throat trouble had disappeared, and albumen was no longer present in the urine.

About the 1st of March the patient began to complain of cramps in the umbilical region; these lasted some eight or ten minutes, and occurred usually once or twice daily. Opium relieved these cramps, but did not prevent their return. During the night of the 22d of April he was suddenly seized with violent contractions of the abdominal muscles, especially of the recti. In three days these contractions had extended to the muscles of the right forearm and to the muscles of the lower extremities; more marked, however, in the right than in the left. Touching the chest or abdomen would bring on these contractions, or if present would increase their severity. The most sensitive point was directly over the xiphoid cartilage. Touching it would be quickly followed by jerkings both of the abdominal muscles and of those of the lower limb. These muscular spasms were so severe as to nearly throw the patient out of bed. They would occur during the waking as well as the sleeping hours, and were attended with pain in the lumbar spinal region. At times there were sensations as of ants crawling over him. In the muscles there were almost constant fibrillar contractions, which were much increased when the limbs were handled. The calf muscles were less affected than were those of the thigh. The fibrillar twitchings were more marked in the right than in the left lower limb. Both these extremities were quite rigid, but could be flexed or extended without pain by a strong exertion of the patient's will or by another's assistance. In the right forearm there were slight fibrillar twitchings, but in the left there were none. Prior to this attack he had been confined to the bed, but whether from nerve-exhaustion or because of the weakness incident to the precedent variola, laryngitis, and albuminuria, did not seem clear. The muscles of the lower limbs were somewhat emaciated. An interrupted electrical current applied to the right lower extremity produced such excessively violent contractions as to nearly throw him from the bed. When applied to the left extremity, musculo-contractility did not seem above par, but fibrillar twitchings would occur in the right lower limb, and to a slight extent in the left. No muscular jerkings, however, would be occasioned. There was decided loss of general sensation throughout all the affected portions. He had most of the time slight vertical headache, with some weakness of vision. Any endeavor to stand or walk would produce such jerkings as to render the attempt unavailing. He could sit up a little in a chair, but spent most of the time in bed. There were no passages from the bowels without the aid of active purgatives. Urination was normal.

During the earlier weeks of this attack, the patient took large doses of iodide of potassium without any apparent benefit. During a portion of May he had hypodermic injections of Fowler's solution without any effect. On May 12 he received a hypodermic of $\frac{1}{60}$ gr. of sulphate of atropia, which produced in two minutes sensations of dryness and constriction of the pharynx, and also relieved the muscular spasms for several hours. For several weeks afterwards, the patient received $\frac{1}{75}$ gr. of this drug hypodermically once daily, with the effect of diminishing the frequency and intensity of the muscular jerkings. For a few days this remedy was suspended and a continuous electrical current was passed along the spine. The contractions increased in intensity, and the atropia was resumed and again produced an amelioration. During the month of June a continuous current was passed daily along the spine, and the atropia was administered only at intervals of several days. The electricity did not produce muscular contractions as at first, and the only phenomena attending its use were the usual ones of a burning under the electrodes and a coppery taste in the mouth.

On July 1 the following was the man's general condition: the bowels remained generally constipated, but there was no difficulty in micturition. The muscular jerkings and fibrillar movements in the right lower extremity, though still present, were less marked. Both present to some extent in the left one. In both legs there was wasting of the muscles, but this was most decided in the left one. There was then almost constantly a pain in the left knee, and a numbness, with a feeling of "pins and needles" throughout that extremity. An induced current along the right limb brought on violent jerking. A mild current to the left limb produced slight action of its muscles, with choreic movements of those of the right leg. A stronger current to the left thigh produced repeated and excessively rapid general spasms of the muscles of the right limb, raising it entirely, and elevating the foot 240 times per minute. These jerkings continued for several minutes after the removal of the electrodes, and were accompanied with pain along the lumbar region. For a few days during July there seemed to be a decided improvement, and the patient could almost stand alone. On the 27th of that month, however, the muscular spasms suddenly returned with

great violence, and seemed to involve the muscles from the head down. Accompanying these spasms there were fierce darting pains in the hips and thighs, with intense aching pain in the lumbar region and severe pain in the posterior portion of the head. In a few days the severity of these symptoms diminished, and the jerkings became confined to the muscles of the lower half of the person and the right upper extremity. The use of electricity was suspended. The iodide of potassium and the bromide of potassium, five grains of each, were directed to be taken three times daily.

December 1, 1872.—Since the last date the last two remedies have been taken with occasional suspension. There has been no decided change in the symptoms. The muscular jerkings still persist, unless controlled by some remedy. The one that acts most satisfactorily is a hypodermic injection of sulphate of morphia gr. $\frac{1}{4}$ and sulphate of atropia gr. $\frac{1}{60}$ in combination, this being used once or twice daily. The emaciation of the lower extremities has increased, yet the patient can still sit in a chair. Constipation continues troublesome. The bladder and kidneys act well, the urine being normal.

What then, gentlemen, is the nature of the disease of this man's spinal cord? The symptoms resemble those of sclerosis. Remember that the change in the connective tissue is a slow one; that the atrophy of the nerve-structures and the obliteration of the blood-vessels come on slowly, and that hence the symptoms must gradually show themselves and gradually become more marked. If the anterior and lateral columns are affected, there will be in disturbed motility, evidences of excitement, congestion, and irritation of the cord, before the pressure is sufficient to produce paralysis; reflex action will become excessive; and muscular twitchings, with fibrillar movements, local spasms, and rigidity, supervene. Striking the muscles in this case quickly produces repeated clonic spasms, lasting, perhaps, for a few minutes; the application of an electrical current brings about these twitchings in a most marked manner. There are, besides, spontaneous contractions of the abdominal muscles, making the walls of that cavity firm and tense. Sometimes the muscular jerkings are so severe as to throw the patient out of bed. When the muscles are temporarily unexcited, extension and flexion are not accompanied with pain; a fact to be borne in mind in differentiating this affection from chronic spinal meningitis. In the latter disease the spasms partake more of a tonic nature, the muscles are more rigid, with occasional spasms, and movements are accompanied with pain in the muscles as well as in the back. In sclerosis pain in the back may accompany the spasms, but there is no severe pain in the muscles. In the man before us the anterior and lateral columns were first involved, and as the pressure increases paralysis will become more and more marked until complete. Slowly it seems to be extending to the posterior columns, and sensation is gradually becoming affected. The disease will probably extend up the cord until the medulla becomes involved, when death must result from disturbance of the roots of the phrenic and pneumogastric nerves.

The man states that he has had a similar attack before, and recovered. I do not know whether this is correct or not; but it is possible, although I never saw such a case, that in the early stages the diseased action in the cord may cease for a time, and great amelioration take place; an amelioration which is, however, only of a temporary nature.

The treatment of sclerosis of the cord, like that of cirrhosis of the liver, is most unsatisfactory. Various remedies have been faithfully used without any apparent positive benefit. The electrical current in this case did no good, and the iodide of potassium was used with the same result. The regular progress of this disease has not been materially affected by any treatment as yet proposed for it.

(To be continued.)

ORIGINAL COMMUNICATIONS.

CYST OF THE IRIS—REMOVED BY OPERATION.

(With a Lithographic Plate.)

BY GEORGE STRAWBRIDGE, M.D.,

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THE history of the case, as given by the patient, Mr. G., æt. 70, is, that one year ago an unusual watery condition of the left eye was noticed, which gradually increased, and especially so when encountering a strong light, which caused such a degree of lachrymation that vision was thereby seriously interfered with. The eye was also painful. A few months later, the sight of the eye had decreased to such an extent that reading or writing was impossible, while the lachrymation was so great that, on attempting to write with the aid of his right eye, the paper was as if sprinkled with water. The pain had increased, and was of a smarting, burning character. The right eye had also become sympathetically affected, so that the light caused him great annoyance; while the amount of use he derived from it was very limited.

At the time of my examination, one year from the commencement of his trouble, a perfectly transparent cyst was visible in the anterior chamber of the left eye (see Fig. 1), in its outer lower quarter, having a height of five millimetres, and at its base a breadth of eight millimetres, and oval in shape. Oblique illumination showed it to be clear fluid contained within a transparent membranous bag.

The iris, which could be distinctly seen through the body, was pushed backward, causing it to be deeply concave at that point, and of a much darker color, by reason of its black uveal layer being brought into view. The cyst filled up the space between the iris and cornea completely; and the cornea directly over it was slightly cloudy. The pupil remained round, with slight abnormal dilatation, while the crystalline lens had become cataractous. Congestion of the conjunctival and ciliary blood-vessels existed to a moderate degree. Tension of the eyeball was slightly increased, and any amount of pressure caused pain.

The patient found the pain and annoyance to the right eye to be so rapidly increasing that he readily submitted to the operation for its removal.

A puncture was made in the periphery of the cornea, just below its horizontal meridian, with a Graefe cataract-knife, which was then passed downwards in the anterior chamber (transfixing the cyst in its passage), and the counterpuncture made at a point three lines distant from the puncture, and the cut completed. The collapsed cyst was then seized with a small curved iris-forceps, and gentle traction used to effect its removal. It soon became evident that the cyst and iris were firmly bound together, and the greatest care was required to prevent separation of the entire iris. Its complete removal was finally accomplished, together with that of the underlying iris-tissue.

No complication followed, and the eye healed rapidly. Fig. 2 represents the eye eleven months after the operation. The pupil is drawn outwards and downwards towards the old corneal opacity, causing the change in its shape; the loss of iris by the operation is also seen. The condition of the cornea and lens shows no change. Tension of eyeball good; the patient is entirely free from any pain or discomfort in either eye, and is able to use his right eye in reading and other fine work at pleasure, and there is no sign of return of the cyst.

Examination of the cyst showed it to belong to that class having a delicate membranous wall with epithelial lining and clear fluid contents. It evidently originated in the iris.

Mr. Hulke,* in his admirable report on cysts in the iris, has collected the histories of twenty-one cases, reported by Tyrrell,† Wharton Jones,‡ Dixon,§ Guepin,‖ Bostells,¶ Graefe,** Wordsworth,†† Mackenzie,‡‡ Turner,§§ Combessir,‖‖ White Cooper,¶¶ Stoeber,*** Richard,††† Haynes Walton,‡‡‡ and Hulke.§§§ To these add one case published by Fischer,‖‖‖ one by Graefe,¶¶¶ one by Arlt,**** six by Mooren,†††† one by Wecker,‡‡‡‡ one by Knapp,§§§§ and the one now published, making a total of thirty-three cases published up to the present date.

In these cases the cysts were found in size from that of a small pea to one four lines in height. They also exhibited great variety in color, some having a glistening white appearance like a pearl or the tendon of a muscle, others of a more bluish cast, the remainder being brown, reddish brown, or opaque brown.

The cyst-wall in some cases was found to consist of a transparent membrane with epithelial lining, while in others it was thick and tough, like cartilage; and the researches of Bowman and others have proved that in a great number of cases the cyst-wall is formed by the rarefied tissue of the iris, and that the uveal pigment forms the epithelial covering of the inner wall of the cyst.

The cyst-contents may consist of a clear, limpid fluid, or they may be thick, opaque, and gelatinous, or they may be composed of epithelium, fatty matter, cholesterine, and hair, as in the case reported by Graefe.*

The origin of the cyst may be either in the iris, or in the ciliary bodies, or in the portion of iris-tissue involved in the sclero-corneal cicatrix.

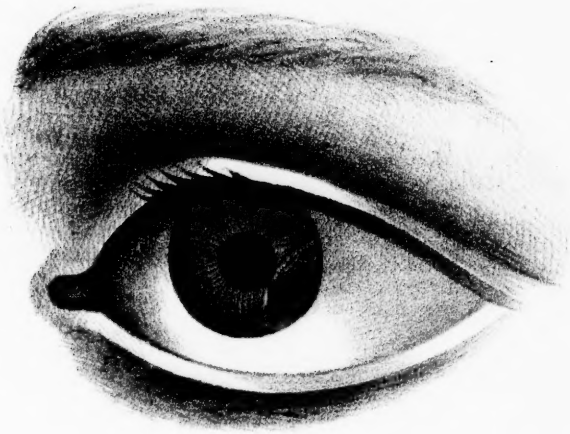
In more than two-thirds of these cases the eye had sustained some previous injury, such as a penetrating corneal wound; and this suggested to Mr. Hulke the idea that in some instances the cyst may originate out of a portion of Descemet's membrane, which may have been torn away from the back of the cornea by the penetrating body and carried before it into the iris.

Wecker considers these cystic growths to be the result of sacculation of the iris, and the enclosed fluid to be the aqueous humor. The iris becomes attached to the posterior wall of the cornea (often after penetrating wounds of the cornea) in such a way that an opening is still left in the adherent parts, through which the aqueous humor enters, and this finally develops into a cyst. This would very well account for that class of cysts occurring in eyes which have previously suffered from irido-choroiditis with synechial formations, or where the sacculation has been produced by a penetrating wound; but in another variety of cases where the cyst has developed without any previous cause, Mr. Bowman's theory† is much more plausible,—namely, that they are due to a morbid collection of fluid between the iris and its uveal layer, and that the first formation of the fluid is attended with a swelling of the uvea backwards towards the suspensory ligament and the lens, but, as the contact of these resisting parts must very speedily arrest any further advance in that direction, the accumulating fluid next begins to push forward the proper tissue of the iris. The highly extensile fibres of the iris slowly yield, until in the course of months they bulge before this fluid, and finally come in contact with the cornea, and sometimes may cause the pupil to be thrown towards the opposite side or to be rolled in front of it. This view is also confirmed by microscopic examination, which shows that the cyst-wall is often to a great extent made up of distinct iris-tissue with the uveal pigment layer forming the inner epithelial covering. This theory would explain the occurrence of the cyst in the case now published.

Graefe insists that, in some instances at least, the cyst must be regarded as a new formation, and supports his view by a case of dermoid cyst of the iris which contained epidermis and hair with amorphous fat and cholesterine.

* Ophth. Hospital Reports, vol. vi. p. 12.
† Tyrrell on the Eye, vol. i. p. 368.
‡ *Lancet*, xvi., 1852, p. 120.
§ Dixon, Ann. d'Oc., tome xxxvii. p. 141, 1857.
‖ Guepin, Ann. d'Oc., tome xliv., 1860.
¶ Bostells, Ann. d'Oc., tome lii., 1864, p. 175.
** *Archiv für Ophthalmologie*, Bd. xii. Abth. 2, S. 228.
†† Unpublished.
‡‡ Mackenzie, edit. iv. p. 704.
§§ *Monthly Journal of Medical Science*, vol. i. p. 270, 1841.
‖‖ *Gazette Hebdomadaire*, 1855.
¶¶ *Journal of Medicine*, Sept. 1852, p. 789.
*** *Gazette Hebdomadaire*, tome ii. p. 55.
††† *Ibid.*, tome i. 1082.
‡‡‡ *Medical Times*, August 5, 1854, p. 139.
§§§ Ophth. Hosp. Reports, vol. vi., 1869, p. 12.
‖‖‖ Lehrbuch der gesammten Entzündung und organische Krankheiten des Auges, 1846, p. 11.
¶¶¶ *Archiv der Ophth.*, Bd. iii. Abth. ii. p. 412.
**** Arlt, Lehrbuch, Abth. iv. p. 109.
†††† *Klin. Monats.*, b. p. 362, et Ann. d'Ocul., tome liv.
‡‡‡‡ Archives of Ophthalmology and Otology, vol. i. part i p. 86.
§§§§ *Ibid.*, vol. i. part ii. p. 411.

* *Archiv f. Ophth*, Bd. iii. Abth. ii. p. 412.
† Lectures on the Parts concerned in Operations on the Eye, p. 75, London, 1849.



LARGE CYST OF IRIS.

EYE. - AFTER ITS REMOVAL.

DOUBLE LIFE SIZE.

As the histories of all cysts of the iris show that, if allowed to remain, they invariably become the cause of inflammatory action in the eyeball, in the form of a choroiditis or irido-choroiditis, with often sympathetic inflammation of the other eye, the indication is always to remove them as soon as possible before impairment of sight has occurred.

Puncture of the cyst has been repeatedly tried, but is so generally unsuccessful that excision is much to be preferred; although the latter operation is not unattended with risk.

A CASE OF POISONING BY STRYCHNIA—RECOVERY.

BY GERALD D. O'FARRELL, M.D.,
of Philadelphia.

ON the 22d of January I was called to see I. W., aged 50 years, a German baker. He had been drinking freely for a month past. A few days previous to my visit he had obtained from a drug-store in the vicinity two grains of strychnia, under pretence of wishing to poison a dog. He was rational, and admitted that he had taken the poison for the purpose, as he expressed it, "of spiting his wife."

I found him on a settee, his extremities cold and rigid, with so much subsultus tendinum that I was unable to feel any pulse; his face and body livid, the expression of his countenance hideous, and his respiration very difficult. He complained of intense pain in the pit of his stomach.

Ascertaining that the poison had been swallowed six hours, and that he had just before my arrival taken an emetic of sulphate of zinc sent him by the druggist from whom he had obtained the alkaloid, I could see no advantage to be derived from the use of the stomach-pump. There was slight emesis of a glairy white fluid slightly tinged with blood. I ordered him f℥i doses of chloroform every half-hour until relieved, and every hour after. I also gave him tannic acid in five-grain doses, frequently repeated, with large doses of animal charcoal at intervals. After the chloroform had been administered as above for eighteen hours, he slept; and when he awoke he expressed himself free from pain, but complained of being unable to stand, his limbs having no power to support him. The following day he was well and at his work.

NOTES OF HOSPITAL PRACTICE.

EPISCOPAL HOSPITAL.

CASE OF TETANUS, FOLLOWING BURNS, FATAL IN LESS THAN TWELVE HOURS.

Reported by LOUIS STARR, M.D., Resident Surgeon.

CHARLOTTE S., æt. 17 years, admitted to Dr. Packard's ward in the hospital, December 27, 1872, suffering with extensive burns, and a compound comminuted fracture of the right femur; caused by the explosion of the water-back of a kitchen range.

The burns were situated on back of neck and head, left shoulder and forearm, right forearm, left thigh and leg; the destruction of tissue being superficial, except in two places, one on the shoulder, the other on the thigh, where for an area of about two square inches it extended below the true skin.

The right femur was fractured at the junction of its middle and upper third; there were two wounds on the outside of the right thigh: the upper one, three inches in length, communicated with the bone at the seat of fracture; the lower wound, situated just above the knee-joint, was about an inch and a half long, and quite superficial. On admission, one day after receiving the injury, she complained of great pain, but her general condition was moderately good; there was little or no bleeding; her pulse was frequent, but strong; the temperature of the surface slightly raised, and a tendency to nausea.

The wounds in the right thigh were dressed with carbolic acid cerate, and weight extension applied to the leg; the burns with lard covered with cotton; and the patient was ordered a fever mixture, milk punch, and a milk and beef-tea diet. In the evening gr. ¼ of morphiæ sulph. was given by hypodermic injection.

December 28.—Condition slightly improved; less fever; pain in leg not so severe; stomach able to retain food.

December 29, 30, 31.—Condition still improving; pulse less frequent; sleeps moderately well; able to take some solid food; large but healthy discharge from wounds; treatment continued—gr. ¼ of morph. sulph. given each night by injection.

January 1, 1873.—[Dr. John Ashhurst, Jr., took charge of the ward.] Fever has subsided; complained of some pain in back of neck, which was entirely relieved on washing and redressing the burn situated there; fever mixture stopped; ordered iron and quinine; other treatment continued.

January 2.—Took through the day ♏ x ol. terebinth. in addition to the iron and quinine; at 6.30 P.M. felt rather more restless and uncomfortable than usual; f℥ij of liq. morph. sulph. were given by the mouth; passed an uncomfortable night.

January 3.—Pulse much more frequent, with a general febrile condition; tendency to diarrhœa; some slight twitching of muscles of arms and legs; turpentine mixture suspended, and f℥i of spt. eth. comp. ordered in its place. At 12 M., half an hour after taking the first dose of the anodyne, vomiting and purging came on; at 4 P.M. had taken three doses of spt. eth. comp. with no appreciable effect; spasmodic action of muscles still continued; face pale; skin hot and bathed in perspiration; at 4.30 she was seized with a well-marked convulsion, which lasted but a few minutes, when her jaws became locked, the muscles of the abdomen rigid, and the body arched backwards; in this condition she remained—with but a short interval, when the jaws were slightly relaxed—until the time of her death, at 6 P.M.

Several unsuccessful attempts were made to administer calabar bean.

THE *Druggists' Circular* gives the following as the formula for "juniper tar soap:"

℞ Oil of juniper, 1 fl. ounce,
Soft soap, 1 fl. ounce,
Alcohol, 1 fl. ounce. Mix.

The same journal answers a correspondent who asks if there is any varnish which will protect surgical instruments from rust, as follows: "There is; but we do not recommend it for such a purpose, though it is very useful to protect steel under other circumstances. Here it is: Melt common resin with a little Gallipoli oil and spirits of turpentine in proportions adapted to the particular case. The varnish should adhere firmly, not chip, and yet be easily removed. We have recently seen a mixture of carbolic acid and olive oil, recommended in an English paper; but paraffine dissolved in benzine is said to be still better. We do not think that the simple mercurial ointment can be much improved upon for delicate instruments."

PHILADELPHIA
MEDICAL TIMES.
A WEEKLY JOURNAL OF
MEDICAL AND SURGICAL SCIENCE.

The Philadelphia Medical Times is an independent journal, devoted to no ends or interests whatever but those common to all who cultivate the science of medicine. Its columns are open to all those who wish to express their views on any subject coming within its legitimate sphere.

We invite contributions, reports of cases, notes and queries, medical news, and whatever may tend to increase the value of our pages.

All communications must bear the name of the sender (whether the name is to be published or not), and should be addressed to Editor Philadelphia Medical Times, care of the Publishers.

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SATURDAY, FEBRUARY 15, 1873.

EDITORIAL.

THE PHARMACOPŒIA OF THE UNITED STATES.

THE new edition of the "United States Pharmacopœia," which within the last few days has issued from the press of J. B. Lippincott & Co., of this city, is a model of excellence in every respect, and does honor to all who have had any share in the work of its revision and publication. As a specimen of bookmaking, with its clear, sharp type, its general neatness, and its superior paper, it cannot be excelled by even the far-famed Riverside Press. But it is not merely as a fine specimen of typography that we are to look at this volume: it is one of the most valuable works published in this country. What Blackstone is to the lawyer, nay, even more, is the Pharmacopœia to the pharmaceutist, and through him to the physician and the community. The "Committee on Revision" has done its work faithfully and well.

Some may be inclined to find fault, some may say that this or that preparation might have been made more agreeable to the palate, or to the eye, in some other manner; perhaps so, but excellence gained in one way is often lost in another, and the efficiency of a drug is of much greater importance than its appearance or taste. The superiority of this edition to the preceding one is great, not only in the additions to the materia medica, but also in the introduction of several classes of preparations which are not to be found in any former edition, and in the weeding out of useless matter.

Upon opening the volume we find the "Proceedings of the National Convention of 1870," telling us of the appointment of the "Committee of Revision and Publication," which committee consists of some of the most honored men in the professions of medicine and pharmacy in this country.

Next comes the Preface, which gives us some insight into the immense amount of work the committee has performed.

Dr. G. B. Wood, in an introductory lecture delivered at the University of Pennsylvania, November 2, 1842, used the following words: "At this very moment, in the rage for novelty, we are threatened with an innovation in chemistry, which promises to subvert some of the facts of the science previously thought to be among those best settled, and to work an almost complete revolution in its nomenclature. The salts are no longer to be compounds of acids and metallic oxides, but of certain complex radicals with the metals themselves."

The "revolution in nomenclature" foreshadowed here has at last come upon us, and the new Pharmacopœia, "without adopting the new nomenclature of chemistry to its full extent," has adopted it to the extent necessary "to give uniformity; all the salts of the alkaline metals are designated as of the particular metal, not of its oxide." Though the new nomenclature may give us trouble at first, it certainly is a step in advance, and a step not prematurely taken. We fear it will take many a long day to unlearn and relearn the names of our old chemical friends.

The "Preliminary Notices" have not been altered from those of the last edition, and consist of notes on weights and measures, temperature, percolation, powders, etc.

The primary list of materia medica has been altered by the addition of twenty-four articles, among which we find carbolic acid, oxalate of cerium, chloral, iodoform, and other important drugs. Three articles have been added to the secondary list, and four dismissed from it, none of these being of much importance. We also find that the number of preparations has been increased by the addition of eighty-two new ones, while seven have been stricken off. Among the former, we notice many that bid fair to be of much use, and we are glad to welcome the new classes Chartæ, Glycerita, Suppositoria, and Succi.

The use of glycerin, and the lessening of the quantity of alcohol, in the fluid extracts, will meet the approval of those who are opposed to the use of the latter liquid.

A number of alterations of position and of

names have been made which need not be particularly mentioned here.

The last few pages of the volume are filled with several valuable tables of weights, measures, etc., ending with a copious index.

The history of the Pharmacopœia may not be familiar to all our readers, and to some a short sketch of its history and the sources of its authority may be interesting and instructive.

The first work on materia medica published in this country was the American Dispensatory of Dr. John Redman Coxe, which appeared in 1806. The Pharmacopœia of the Massachusetts Medical Society was published in 1808; this Pharmacopœia was also adopted by the Medical Society of New Hampshire. The next work on this subject was the American New Dispensatory of Dr. James Thacher, bearing the date 1810. In 1816 the Pharmacopœia of the New York Hospital was published, and the next year gave birth to Dr. Chapman's work on Materia Medica and Therapeutics. But the want of a national standard was still badly felt, for the difference in the preparations made according to different authorities created great confusion in regard to strength, dose, etc.

The first proposition to form a Pharmacopœia for Pennsylvania was made to the College of Physicians of Philadelphia on the 1st of May, 1787, by Dr. John Morgan; the proposition was not fully considered then, but was taken up again in 1789, and at several different times, until in 1797 the subject seems to have been dropped.

In 1817, Dr. Lyman Spalding, of New York, presented a plan for a National Pharmacopœia to the New York County Medical Society, and this society issued a circular calling for "the assembling of four district conventions severally composed of medical delegates from the Northern, Middle, Southern, and Western States." These conventions were each to compile a Pharmacopœia and to send delegates to a general convention. This general National Medical Convention assembled in the Capitol at Washington on the 1st of January, 1820, and was composed of delegates from the following societies: the Medical Societies of Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New Jersey, Delaware, Ohio, Indiana, South Carolina, Georgia, and the District of Columbia, and from Brown University, Yale College, the College of Physicians of Western New York, of the City of New York, and of Philadelphia, and from the Medical Convention of Maryland.

This convention formed the first Pharmacopœia of the United States, and provided for the assembling of a similar convention every ten years for the purpose of its revision.

The first edition of this work did not meet with general favor, and before the ten years had passed it was almost forgotten. But the importance of the subject and its practicability had interested in its favor some of the great lights of the medical profession. Dr. Samuel L. Mitchell presided at the first convention; Dr. Thomas T. Hewson was its secretary. Dr. Franklin Bache published a review of the first edition in the *American Recorder* in 1821.

In 1829 the College of Physicians of Philadelphia appointed a committee consisting of Dr. Hewson, Dr. Bache, and Dr. G. B. Wood; this committee prepared a Pharmacopœia, which was adopted by the college and afterwards by the national convention of 1830, and was published by the revising and publishing committee of that convention, after having been submitted to the Philadelphia College of Pharmacy and meeting with their approbation, in April, 1831. This edition was very generally accepted, and became the standard authority.

The convention of 1840 invited delegates from pharmaceutical colleges; and since that date these institutions have taken an active part in the preparation of the Pharmacopœia.

The first and second editions were published both in Latin and English. In the edition of 1840, and in the subsequent editions, the Latin language has not been used, except for the names of medicines and preparations.

Thus every ten years a convention composed of delegates from our most important medical and pharmaceutical societies meets at Washington to revise and republish the Pharmacopœia.

Among the names of those who have been influential and active in these conventions are many of whom Philadelphia may be proud,—Bache, Hewson, Wood, Carson, Bridges, Parrish, Procter, and many others. Our own College of Physicians has always been in the front rank of the workers in this good cause. F. A. H.

A NEW SANITARY "JOB."

WE see noticed in the daily papers a plan, which is said to have taken shape in a bill before the State Legislature, for a "Board of Sanitary Officers" for this city. The said Board, to be called the Street-cleaning Department, is to consist of six men named in the bill, who are to be placed in office until 1877, and are to have the entire charge of the removal of all dirt, garbage, dead animals, ashes, etc. They are to be clothed with

power to order the paving of streets when they think proper, and the bills for the work so done must be countersigned by the City Controller, and must be paid by the City Treasurer.

What checks are to be placed upon the six to insure their proper fulfilment of the duty of keeping the streets clean and well paved, and to prevent lavish expenditure of the public money by them for the benefit of contractors or hungry politicians, we do not know, not having seen the proposed bill.

But we do not think any man of average intellect can fail to see how a plan of this kind is likely to work. Certainly the six would have more than ordinary political virtue if they let slip the opportunities it would afford them of lining their own pockets at the expense of the public treasury. And he must be a simple-minded man indeed, who would look for clean or well-paved streets under such a system. On behalf of the sanitary interests of the city, we protest against this palpable "job." It would be far better to increase the powers of the Board of Health, and leave the matter in their hands.

LEADING ARTICLES.

THE HEALTH OF 1872.

IN looking over the reports of mortality of the past year, we find that the most remarkable phenomenon—more remarkable even than the epidemic of smallpox—was the increase of mortality caused by the excessive heat. The mortality in 1872 was greater from cholera infantum in the single month of July than ever before in the whole year.

The hottest summer of which any record has been kept was, until last year, that of 1870; and in 1870 the deaths from cholera infantum were 1002 in number. In 1872 the deaths from that cause amounted to 1666; 1080 of them in July, 324 in August, 143 in June, and 59 in September. 1221 of the deaths from cholera infantum were of children under one year,—more than one-fifth of the total mortality at that period of life, viz., 5862. 413 died from cholera infantum between the ages of one and two, and 32 between two and five.

But it was not only thus that the effect of the heat was shown. There were 136 deaths from sunstroke, to 11 the year before, and 52 in 1870,—the hottest summer previously known. Even in adults and independently of sunstroke was the effect of the heat shown. This is very unusual; for after the age of two we seldom or never before have seen the mortality increased by heat. But in the summer of 1872 the deaths in July were more numerous even among adults than in any other month except January alone, when smallpox was at its height.

In comparing thus the mortality caused by these two scourges of humanity, we find that in one respect they were analogous: both attacked children preferably. From smallpox about one-ninth of the mortality was in children under one year; from cholera infantum a much larger proportion, three-fourths of all the deaths being of children at that age. As regards duration, however, the two diseases were very different. Smallpox extended over a year, cholera infantum over the summer only; but during midsummer, and among children under one year, the mortality in July, when the hot weather was most intense, was nearly ten times as great from cholera infantum as ever in any one month from smallpox even at its height: so that in this respect it may be truly said that the mortality from cholera infantum was more remarkable than that from smallpox, although the total mortality in 1872 was only two-thirds as great.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY, JANUARY 9, 1873.

(Continued from p. 301.)

DR. J. EWING MEARS presented specimens of *uterus and both ovaries in a state of cystic degeneration, together with both kidneys, showing dilatation of their pelves.*

The specimens were removed from a patient of Dr. J. Ralston Wells, of Hestonville, whom Dr. Mears saw with Dr. Washington L. Atlee in April last. On that occasion Dr. Atlee tapped the patient, removing a bucketful of fluid from the abdominal cavity. This fluid was of a mixed character, the first portion evacuated being serous, then becoming sero-purulent, and finally changing into pus. At the time of the tapping the patient was suffering from an attack of acute peritonitis, the pulse was 130, small and wiry, the exhaustion was extreme, and death appeared imminent. Her condition was such that it was feared she would not survive the operation of tapping. With a view to relieve the dyspnœa which was produced by the accumulation of fluid in the abdominal cavity, and thus to render the patient more comfortable, the operation was performed.

Contrary to expectation, the patient recovered, not, however, without an extreme illness extending over seven weeks.

After removal of the fluid, a tumor of somewhat large dimensions was detected occupying the left side of the abdomen in its lower portion. On account of the patient's condition, no examination was made for the purpose of deciding its character. After the attack of peritonitis the patient enjoyed fair health, being able to perform light household duties and take exercise in the open air. A few days before her death she became quite prostrated, and died presenting some of the symptoms of uræmic poisoning. Her physician, Dr. Wells, stated that the secretion of urine gradually diminished, ceasing almost entirely twenty-four hours before death.

December 31, 1872.—Autopsy by Dr. Mears, assisted by Dr. Wells. Examination limited to abdominal cavity. The abdomen was uniformly distended, and about the same size as in the eighth month of pregnancy. Over the position of the tumor on the left side fluctuation was present, but indistinct and limited by the median line. On the right side fluctuation was more distinct, and was also limited by the median line.

On cutting through the linea alba, the knife divided a portion of intestine, which was found on examination to be the ascending portion of the colon, sealed to the under surface of the abdominal wall by extremely thick and dense layers of adventitious tissue. It passed obliquely across the cavity in a direction from the inguinal region to the umbilicus; its outline could not be detected on the under surface of the wall, so uniformly thick were the layers of the adventitious tissue. Corresponding to a line drawn from a point just below the umbilicus outwards, this adventitious membrane was reflected from the anterior to the posterior wall of the abdominal cavity, forming a distinct septum or false diaphragm; thus enclosing a space which was bounded on the left by the large cyst occupying the left side of the abdomen, above by this septum, and in the other directions by the abdominal and pelvic walls. This cavity contained four pints of turbid fluid with flakes of lymph floating in it. Above this septum the intestines were found pushed up in contact with the stomach. There were no signs of inflammation beyond this septum. The serous coat of the intestines was smooth and glistening, and the intestines were freely movable upon each other. The stomach, spleen, and liver were normal, and free from inflammatory adhesions. The kidneys were about one-third the normal size; their pelves appeared largely dilated, owing to absorption of the greater portion of the medullary substance of the organ. The upper portion of the ureters was dilated; the ureters were firmly pressed upon by the large cyst in their course to the bladder. This organ was empty.

Both ovaries had undergone cystic degeneration; the left was very large, multilocular in character, and firmly bound down in both abdominal and pelvic cavities by strong, dense adhesions. The right was about the size of a large orange, and was, like the left, attached to the uterus by broad and dense pedicles.

In presenting the specimens, Dr. Mears desired to call the attention of the members of the Society to points which he regarded of interest. First, in reference to the fact that paracentesis was performed during an attack of acute peritonitis, which was found by post-mortem examination to have been distinctly circumscribed and limited by the false diaphragm. In considering this subject, the question suggests itself as to the effect exerted, for good or bad, by the tapping. Did it in any way modify the morbid condition? At first sight he was inclined to regard the condition of the kidneys as due to the obstruction produced in the ureters by the large cystic tumor of the left ovary, which was so firmly fastened by adhesions. He had not submitted them to microscopic examination, and could not state whether there were any evidences of structural disease.

In the case of the right ovary he was induced to believe that it presented an instance of cystic disease, developed subsequently to the attack of peritonitis, and caused by the inflammation which interfered with and prevented the proper performance of the function of the ovary,—producing an inflammatory thickening of the capsule, which, as Rindfleisch states, was able to resist the forces which cause a rupture in the normal condition of the capsule and in this way set the follicle free. The accumulation of fluid in the follicle may lead to the formation of a cyst.

Dr. J. V. INGHAM asked Dr. Mears on what grounds he based his statement that the disease in the right ovary did not exist prior to May last. He thought the circumstance that menstruation ceased at that time was scarcely a sufficient reason in the face of the fact that menstruation sometimes continues after both ovaries have been removed. Dr. Ingham thought, too, that the amount of disorganization in the right ovary was too great to permit him to believe that it had existed only since May.

Dr. MEARS replied that his statement was based only on the circumstance of the cessation of menstruation.

Dr. INGHAM said he had asked the question on account of the light which he thought might possibly be shed upon the absence of menstruation in cases of parametritis in which the ovaries seem not to have been involved. This might have been the case here. He did not know how to explain the matter, except that the pressure produced a change in the circulation, which did not respond to the menstrual nisus. That the ovaries alone are responsible for menstruation he thought doubtful.

Dr. JAMES TYSON desired to know what symptoms of uræmia were present; since, if the view of Harley, Roberts, and others, as to a difference in the phenomena of blood-poisoning as produced by deficient elimination of urea, and as due to reabsorption of the urea or the products of its further decomposition, is correct, this is a case in which, in consequence of obstruction to the passage of urine into the bladder, we would expect the symptoms of "ammonæmia," so called, rather than of uræmia, *i.e.*, those of a gradual exhaustion without coma or convulsions.

Dr. MEARS replied that so far as he was familiar with them, the symptoms were more like those of "ammonæmia:" at least there was neither coma nor convulsions while the patient gradually sank into death.

The PRESIDENT asked whether there was not evidence of a diseased state of the kidney apart from the dilatation of the pelvis.

Dr. BERTOLET thought there was diminished extent of the cortical substance, a condition which indeed made the pelvis appear larger than it actually was. He also thought, judging from the leathery hardness of the entire organ and the contracted condition of the cortical portion, that, upon microscopic examination, the amount of connective tissue between the tubules would be found abnormally developed.

The specimen was referred to the Committee on Morbid Growths, who reported that—

"The kidney accompanying Dr. Mears's ovarian cysts was found upon microscopical examination to present, in addition to the slight dilatation of its pelvis, marks of chronic interstitial nephritis; the glomeruli and the tunica propria being very much thickened. The reduction of the cortical substance to less than half its ordinary width, together with the marked retraction of the papillæ and columnæ Bertini, must be regarded as the principal factors in the production of the pelvic enlargement, although the ureter may have been compressed, and no doubt was rendered almost completely impervious."

Dr. R. M. BERTOLET presented the following specimens: *cysto-sarcoma proliferum of the mammary gland* with metastasis in the liver and spleen; *cystic degeneration of the ovaries; eversion of the Morgagnian ventricles.*

This interesting group of specimens was obtained from the body of a greyhound. The tumor, about the size of a man's fist, was situated in the lower mammary gland of the left iliac region. The skin is tensely stretched over the uneven nodulated tumor, which has slowly increased in size since its first appearance a little over a year ago. Externally to the nipple there is a

small fistulous opening leading into the centre of the growth; from it more or less pus and blood was constantly discharged.

Upon section, the tumor is seen to be made up of an aggregation of numerous cysts of very variable size, from that of a small pea up to that of an English walnut. Some of the cysts are filled with a dark-red or black substance of a gelatinous consistence; but the majority of the cavities are more or less completely filled with firm, flesh-like masses of granulations springing from the walls of the cysts. The latter constitute the proliferating sarcomatous growth, while the cyst-walls themselves are probably formed by dilatation of the lacteal ducts and sinuses, since in some of the smaller cysts traces of an epithelial lining can still be detected.

Microscopically the tissue of the tumor is of a very variable character, which the great diversity in both color and consistence would naturally lead one to expect. Certain portions, having a dense, whitish, almost fibrous structure, might in themselves be taken for fibromata; other portions of the growth have a soft, medullary appearance. But it is the latter portion, composed entirely of a cellular and vascular structure, that designates the sarcomatous character. Its cells are round, and contain a nucleus and nucleolus. The protoplasm of the cells is cloudy and finely granular; intercellular substance scant; the blood-vessels coursing in it wide and numerous. If a thin preparation is carefully pencilled out under water, there is seen a very fine network of connective-tissue fibres, in the meshes of which were seated the above-described small round cells. In addition to these round cells, in a few preparations short spindle-cells were noticeable, but in very limited number. The lymph-glands of the groin, and elsewhere, were not enlarged.

The metastatic deposits thickly strewn over the surface of the liver were of small size; the largest was not as large as a pea. In the spleen only a single deposit occurred, but that was as large as a hazel-nut. The histological characters are like those seen in the primary growths, namely, small round cells with interstitial substance, the latter, however, homogeneous in appearance.

The lungs and heart were healthy; but we have an explanation of the marked dyspnœa and muffled bark that existed towards the close of life in the everted condition of the mucous membrane lining the Morgagnian ventricles, which are seen projecting over the free edges of the vocal cords into the glottic fissure. Both of these sacs are filled with a thin translucent fluid; light being freely transmitted through their attenuated mucous covering. The vocal cords and remaining parts of the larynx are in a healthy condition.

The animal has never been pregnant, yet we find cystic degeneration of both ovaries. Each cyst is about the size of a hickory-nut, and filled with a straw-colored fluid.

In the left cornu of the bifid uterus, about one inch from its free end, is seen another distention, as large as a hen's egg. This is made up of an aggregation of smaller cysts; in other words, it is multilocular, and no doubt corresponds to, and was produced by causes similar to those that give rise to, Fallopian cysts in the human subject. The tube leading from the small ovarian cyst to the larger multilocular cyst was rotated a number of times upon its axis; but that part of the tube or cornu which extended to the main body of the uterus was not observed to be twisted when dissected out.

MEDICAL SCHOOL AT GENEVA.—The Conseil-Général of Geneva, Switzerland, has voted to establish a faculty of medicine in that city.

MEDICAL SOCIETY OF THE COUNTY OF ALBANY, NEW YORK.

A SPECIAL meeting of this Society was held January 14, 1873, the President, DR. A. VAN DERVEER, in the chair.

The PRESIDENT announced the death of Dr. J. P. Whitbeck, of West Troy, in some appropriate remarks. Tributes of respect were also paid to the deceased by Drs. R. H. Sabin, Craig, Moore, W. H. Bailey, H. March, and James S. Bailey.

The regular semi-monthly meeting was held January 22, the President in the chair.

Resolutions were offered by Dr. JAMES S. BAILEY, and adopted, in regard to the death of Dr. JOHN F. CROUNSE.

Dr. WILLIAM HAILES addressed the Society on the subject of the anatomy of necrosis in the connective and muscular tissues, illustrating his remarks by means of the stereopticon.

Dr. E. H. DAVIS read a paper on *pleuritic effusion treated by paracentesis*. After introductory remarks, he said: If there is any doubt as to the nature of the case after having examined the patient in the ordinary manner, we can in most cases, with perfect safety, make use of the exploring-needle to correct or confirm the diagnosis.

Having determined the existence of fluid in the pleural sac, questions arise how, when, and where shall we operate for its evacuation.

If the effusion be serous or sero-albuminous, a reasonable hope may be indulged that by suitable treatment it will, under favorable circumstances, be absorbed, however large the quantity. But if the pleura contain pus, constituting empyema, the hope of absorption is greatly diminished, if not entirely precluded.

Therapeutic agents, as purgatives, iodine, mercury, etc., have but little influence in promoting the absorption of pus, and, if such were possible, its influence might result disastrously.

When paracentesis thoracis becomes necessary, it should be resorted to without delay. The place selected for the opening should be where we are sure there is fluid, and where it can be most readily reached.

Miller, in his Surgery, directs us carefully to avoid the margins of the ribs, but in the cases I have operated upon I have selected the upper margin. In some cases I have used the bistoury, in others the trochar. When there is little or no bulging of the intercostal spaces, or when there is the least doubt as to what may be underneath, I should greatly prefer the bistoury, so as to make an open wound and penetrate the cavity of the chest no farther than to divide the pleura. In other cases, after dividing the integuments the trochar is all that is necessary, and is the most convenient.

Dr. Davis reported the following cases as having been operated upon by himself:

Case I.—J. K., æt. 17, mechanic, in June, while boating on the canal, was attacked with pleuro-pneumonia. In ten days from the attack he was brought home, and I was called to attend him.

He was still laboring under inflammatory action, which continued as many more days, and then began to subside and gave encouragement of recovery; but after a few weeks' continuance of it in the subacute form he began to exhibit symptoms of purulent effusion in the left pleural cavity, which gradually increased, when an operation became necessary for its removal. Previous to the operation the left side of the chest was greatly distended, widening the intercostal spaces over that side from the sternum to the spine, and without my being able to discover the respiratory murmur. There was dyspnœa with frequent cough, with but little ex-

pectoration. The appetite and digestion were greatly impaired, with rapidly increasing emaciation.

Before operating, he was placed in a chair, with his arm resting upon its back. The integuments were divided by a puncture from within outwards, about four inches to the left of the spine, and over the lower margin of the eighth rib. The integuments were then pressed upwards with the fingers of the left hand, and a trochar was passed close to the upper margin of the rib, and ten pints of pus were drawn off; as he became faint, the discharge was stopped with a tent, and the wound was dressed with adhesive plaster and a binder. The next day five pints more were taken, and as much more the day following, which emptied the pleural cavity. The tent was then removed daily, and the accumulating pus allowed to escape. The amount of discharge for the first ten days was estimated at thirty-two pints. His appetite now improved, and he partook of a large quantity of food, and digested it well.

For the next three months he continued to improve, but during the fourth month his strength began to fail, and he died by its completion.

No post-mortem allowed.

The points of interest in this case are, first, the large amount of pus discharged; second, the length of time he was able to sustain this great drain upon his system.

Case II.—G. P., captain of a canal-boat, æt. 33, of strong and vigorous constitution, was taken sick while on a trip to this city. Upon his return I was called to see him, and found him suffering with severe inflammation of the right lung, involving the pleura and already threatening suppuration. His previous treatment had been entirely inadequate to his disease and habit of body.

In a little over a month from the time he came under my charge there was evidence of pus in the right pleural cavity, and, believing that nothing could be gained by delay, I determined to evacuate at once while he had strength. I incised cautiously close to the upper margin of the sixth rib, and drew off five pints of pus, when a tent was inserted and the wound dressed with adhesive plaster and bandage. This was removed daily, and the discharge continued in gradually diminishing quantity for about three months, when it ceased, and the wound healed. At this time his cough was severe and he expectorated pus freely. If at any time he lay upon his right side, he could raise little or nothing, but if he then turned upon his left side the flow of pus would occasionally threaten suffocation, and he would expectorate from a gill to a half-pint in a few minutes, showing that the abscess had not only involved the lung but had formed a communication with the bronchi.

From this time he slowly improved until he completely regained his health.

This was at the time of the rebellion; and at the first call of the North for troops he enlisted in the army, and served with credit through the war.

Case III.—W. D., farmer, æt. 30, while ploughing caught a severe cold, which brought on a difficulty of the lungs, from which he never entirely recovered.

In about one year from this attack I was called to see him. He was then laboring under what I regarded as the inflammatory phthisis of Niemeyer. The right lung was to a great extent disorganized, but the left one was still in a condition to perform its functions.

By means of succussion the presence of air in the left pleural cavity was detected.

He was suffering great difficulty of breathing, and inability to lie down, from the feeling of impending suffocation.

I believed his case hopeless, and so expressed myself to him, but he urged me to operate for his relief. He was placed in a chair, and with a bistoury the integuments were divided, and a trochar was passed through the intercostal space close to the upper margin of the rib near the inferior angle of the scapula, and seven pints of pus were drawn off, greatly to his relief. The difficulty in breathing was relieved, and he could now lie down in bed and rest with comfort, which he had not done before in many weeks. He expressed himself as well satisfied with the result, although he died in less than three weeks from the operation.

No post-mortem was allowed.

There are three questions of interest connected with this case. First, did this pus have its origin in a pulmonary abscess which burst into the pleural cavity? Second, are such large accumulations of matter liable to occur in the course of phthisis pulmonalis? Third, did the relief obtained justify the operation at so late a period?

Case IV.—H. B., son of a farmer, æt. 19, was taken sick, and nearly one month later I was called in council with several other physicians. His family physician informed us that he had considered the disease pleurisy, and we fully concurred in his opinion.

We found him lying upon his left side, unable to change his position without great inconvenience, and his countenance expressed great suffering and anxiety. There was no sound of respiration, either morbid or natural, over the whole left lateral region. The side was a little distended, with prominence of the intercostal spaces. By placing the hand over the region of the heart, I marked the distinctness with which I seemed to feel its concussion against the walls of the chest. The stethoscope revealed the organ pulsating near the margin of the right axilla. I believed the case to be one of hydrothorax, and proposed to evacuate the fluid, but, as there was a difference of opinion on the part of a distinguished physician present, it was thought best to delay. In three days more we met again, and, as we were still unable to agree as to the propriety of opening the chest, we explained the difficulty to the patient and his friends, and, as he was rapidly failing, they expressed a desire that an effort to relieve by an operation should be made. He was accordingly raised in bed to a half-sitting posture, his head turned to the right side, and his left arm moved back out of the way; assistants held him in this position.

I then passed an exploring-needle through the intercostal space between the sixth and seventh ribs, three inches to the left of the sternum, and on withdrawing it water trickled down his side.

A bistoury was then employed to make an incision, two inches in length, through the integuments over the lower margin of the seventh rib.

This was slid upwards by the hand of an assistant to the place where I had previously passed the exploring-needle, and I carefully divided the intercostal muscle when I reached the pleura; this I punctured with a sharp-pointed bistoury, and the fluid discharged with a force that carried it at least ten or twelve inches from his side. It continued to flow until we had a common water-pail half full of a thin slightly albuminous liquid weighing thirteen pounds.

During the discharge of the effusion the heart gradually returned from its abnormal position near the right axilla towards the sternum, and the patient, instead of becoming faint or exhausted, expressed himself greatly relieved. He was gradually reclined over the edge of the bed till he was placed fully on his left side, and at the first sound of ingress of air the integuments were slid downwards, and the wound closed with adhesive plasters and bandage. There was no return of the effusion, and the wound was never reopened. He rapidly improved, and completely regained his health.

The disease left him with the left side of the chest slightly contracted, but the lung was healthy, and he

was able to follow the laborious occupation of a house-carpenter.

Upon motion the Society then adjourned, deferring the discussion upon Dr. Davis's paper until the next meeting.

REVIEWS AND BOOK NOTICES.

A System of Oral Surgery: Being a Consideration of the Diseases of the Mouth, Jaws, and Associate Parts. By James E. Garretson, M.D., D.D.S., Oral Surgeon in the Medical Department of the University of Pennsylvania, late Professor of Principles and Practice of Surgery in Philadelphia Dental College, etc. Illustrated with numerous steel plates and wood cuts. Philadelphia, J. B. Lippincott & Co., 1873.

In the preparation of this voluminous work, in which the author has attempted the difficult task of supplying the needs of the medical man and of the dental practitioner, he has drawn upon an experience not only of wide extent in oral surgery, but also embracing the full range of a general surgical practice, having enjoyed, particularly in the former direction, peculiar advantages for practice in his connection with the University of Pennsylvania. He does not, however, merely present his own experience and opinions, but has drawn largely upon the recorded observations of other authors. Although this may be open to the objection of increasing the size of the book, it adds much to its value, as the reader is thus enabled to compare the various views entertained by eminent histologists and pathologists on the points discussed. The work indeed has been so thoroughly revised, and in many parts rewritten, that it may very properly be esteemed a new book, rather than a second edition of the previous effort of the author. It opens with a concise description of the anatomy and physiology of the oral cavity; followed by the consideration of the pathological aberrations, which, with the therapeutical, surgical, and mechanical treatment indicated in the various affections, are given with a care and attention to detail that will prove of inestimable value to the practitioner, whether engaged in some trying and difficult operation, or in those of a more simple character. The past few years have been remarkably fertile in the production of ingenious labor-saving inventions; all of these have received due attention from the author. Considerable space is devoted to the consideration of Tumors. All tumors are placed under one of two heads,—the "self-explainable" and the "non-explainable;" hernia, dentigerous cysts, steatoma, ranula, hydrocele, aneurisms, etc., belonging to the first class, as such tumors "are in themselves necessarily benign." Every tumor, no matter what its histoid nature or what its situation, that is without a local self-explanation, is placed in the second class, being tumors of a vice expression. While by no means prepared to agree with all the views advanced by the author on this subject and in other directions, we recognize that he has made it one of careful and laborious investigation, and that his opinions are therefore entitled to respectful consideration, particularly as the main object is simplicity in the classification of tumors so as to aid in arriving at an accurate diagnosis. In the perusal of the work and in the preparation of this brief notice of its contents, we have not been indifferent to the unceasing devotion of the author for many years past to his theme, and, sympathizing in the aim to produce a comprehensive treatise on the subject, we have sought out its excellencies rather than endeavored to detect and magnify errors. The work is profusely illustrated, and commends itself alike to the physician, surgeon, and dentist, as a valuable and practical work of reference. The typography and general mechanical appearance sustain the reputation of the house from which it emanates.

BOOKS AND PAMPHLETS RECEIVED.

A Treatise on the Theory and Practice of Obstetrics. By William H. Byford, A.M., M.D., etc. etc. Second Edition; thoroughly revised. 8vo, pp. 469. New York, William Wood & Co., 1873.

The Diseases of the Stomach. Being the Third Edition of the "Diagnosis and Treatment of the Varieties of Dyspepsia." Revised and enlarged. By Wilson Fox, M.D., F.R.C.S., F.R.S., etc. etc. 8vo, pp. 236. London & New York, Macmillan & Co., 1872.

A Treatise on Apoplexy, Cerebral Hemorrhage, Cerebral Embolism, Cerebral Gout, Cerebral Rheumatism, and Epidemic Cerebro-Spinal Meningitis. By John A. Lidell, A.M., M.D., etc. etc. 8vo, pp. 395. New York, William Wood & Co., 1873.

Dental Caries and its Causes. An Investigation into the Influence of Fungi in the Destruction of the Teeth. By Drs. Leber and Rottenstein. Translated by Thomas H. Chandler, D.M.D., etc. With Illustrations. 8vo, pp. 103. Philadelphia, Lindsay & Blakiston, 1873.

Myringectomy, followed by Decided Improvement in the Hearing-Power, etc. By J. S. Prout, M.D., of Brooklyn, N.Y. (From the Transactions of the Medical Society of the State of New York, 1872.) 8vo, pp. 10. Albany, 1873.

Transactions of the Medical Society of the State of West Virginia, for 1872. 8vo, pp. 432. Wheeling, 1872.

GLEANINGS FROM OUR EXCHANGES.

Development of Carcinoma (Waldeyer: *Virchow's Archiv*, 1872, lv.).—This paper contains the results of an examination of 203 cases of primary carcinoma. In 54 cases of carcinoma of the outer portion of the skin, the author makes the following classifications: 1. *C. adenoides*, which closely resembles simple hyperplasia of the glands. 2. *C. papillare*, of which *fibroma papillare* is the prototype, from which it is distinguished by proportionately greater development of epithelium, which fact really decides the character of the tumor. 3. The deeper-seated medullary cancer. 4. The reverse of this form, *C. cutis superficiale*, to which we must join *ulcus rodens*.

In this form of cancer we find at the edges, near the healthy tissue, vascularization of the epithelium. In some cases the capillaries extend into the epidermis, and at the borders of the vessels we find numerous cells which must be considered white blood-corpuscles.

In connection with this excessive growth of epithelium we often find great infiltration of the connective tissue, with new elements, so that between the masses of epithelium true granulation-tissue is found, and we then have *C. granulosum*.

In this form Waldeyer has discovered a transition to certain forms of lupus, in which he likewise found abnormal growths of the rete Malpighii extending into the lupoid granulation-tissue.

5. *C. keratoides.*

In all these forms it is readily shown that the development of the characteristic cell-cones originates from the interpapillary depressions of the rete; sometimes, though rarely, from the hair-follicles and sudoriferous glands. The processes which occur on mucous membranes covered with layers of pavement-epithelium are analogous. Cancers of the uterus, especially those forms belonging to this head, *i.e.*, those of the *portio vaginalis*, show a great inclination to the growth of granulations of the highly vascular stroma, and hence they cause frequent and profuse hemorrhages.

The author next speaks of cancerous forms found in organs possessing cylinder-epithelium, and cites four cases of rectal cancer and two cases of cancer in the large intestines.

The development of the cancerous bodies originates in the follicles of Lieberkühn. In ulcerative forms of cancer of the stomach it is very difficult to decide between carcinoma and simple *ulcus rotundum*.

In fifty-nine cases of carcinoma of the mamma, it was readily seen that in the beginning there is a constant increase in size of the glandular acini, with separation of the same from each other by periacinous growth of small cells. In primary cancer of the kidney and liver it is not difficult to find the origin of the cancerous growths in the uriniferous tubules and the gall-ducts.

Respecting new formations in the brain, Waldeyer is disposed to regard these as plexiform angio-sarcoma, containing cell-elements derived from the perithelial cells of the smallest vessels. He also thinks that there is no proof of the primary occurrence of true cancer in organs *which do not contain epithelium*, as, for example, bone, muscle, lymphatic glands, the heart, blood-vessels, the spleen, serous membranes, and subcutaneous connective tissue, or at least its appearance must be classed among the greatest rarities. In closing his work on the growth of cancer, Waldeyer repeats his theory that all carcinomatous growths originate in pre-existing epithelium, so that the terms cancroid and carcinoma need not be used for purposes of distinction. Cancer is therefore *abnormal* or *atypical epithelial tumor.*

Case of Extra-Uterine Pregnancy (by Dr. Soyre: *Le Mouvement Médical*, January 4, 1873).—The woman was seen in the city by MM. Chantreuil and Guéniot. It was thought, on examination, that she had a fibroid tumor of the uterus, or else that dropsy of the amnios existed. The possibility of the existence of a twin pregnancy was also, for a time at least, thought of.

The patient was sent to the Hôpital des Cliniques. The diagnosis remained uncertain. For the purpose of relieving the dropsy of the amnios a stylet was introduced to perforate the membranes. Perforation of the uterus was the sole result of this operation. The woman died; and it was found at the autopsy—1, that the tumor consisted of the placenta and large clots of blood; 2, that the case was one of extra-uterine (abdominal) pregnancy; 3, that *hydramnios* really existed.

MM. Chantreuil and Guéniot insist on the difficulties of the diagnosis. In this case, the laminated blood-clots surrounding the placenta, attached to the posterior surface of the uterus, imparted to the touch the sensation of a fibrous growth. M. Lionville has recently seen a case of extra-uterine pregnancy at the Hôtel-Dieu, in which the blood-clots were also quite numerous.

A Case of So-Called "Wandering Liver" (Winkler: quoted from the *Centralblatt f. Med. Wiss.*, No. 40, 1872).—Three cases of this abnormal condition have been described by Cantani, Piatelli, and Meissner. To these Winkler adds the fourth case of abnormal mobility of the liver.

In the case related by him, it was possible to press the hand high up into the *excavatio diaphragmatica*, between the costal arch and the liver. In the upright position the liver reached as far as the anterior superior spinous process, and was twisted forward upon its transverse axis. The organ could be replaced. Palpation revealed a normal form and consistence of the liver. The lengthened suspensory ligament could be felt as a sharply defined membranous surface. The cause in this case, as in the other cases, was persistent relaxation of the abdominal wall after pregnancy. An explanation of the icterus in this case may be found in the injury and torsion of the tissues entering the hilus of the liver. The treatment consisted in the application of a firm bandage, made to press from below upwards.

The Thermometer as a Means of Diagnosis in Cases of Uræmia (*Lancet*, Jan. 4).—M. Hanot recently presented to the *Société de Biologie* the notes of a case in which death occurred through uræmia in a patient affected with general paralysis. The uræmic symptoms were produced by pressure of an enlarged carcinomatous uterus on the ureters, and consisted chiefly of a sort of coma and stertorous breathing. The diagnosis was rapidly made out, and the case distinguished from cerebral hemorrhage and softening by means of the rule set down by Dr. Bourneville of considerable fall of temperature in uræmia. In this instance the thermometer showed 34° C at the outset of the symptoms, the following morning 30°, and at the time of death only 20°.

Calabar Bean in Constipation.—M. V. Subbotin recommends, in cases of constipation, the following formula:

℞ Ext. physostigmæ ven., gr. iij;
Glycerinæ, f℥ij.
M. S.—Four drops four times daily.

MISCELLANY.

University of Pennsylvania.—On Saturday last, February 8, by invitation of the Trustees, a large number of influential and representative men, many of them members of the Constitutional Convention or of the State Legislature, met in the new University Building, Thirty-fourth and Locust Streets. A most interesting and instructive tour of the various departments was made, under the guidance of Professors Genth, Lesley, and Frazer, after which a collation was served, followed by several addresses, chiefly from gentlemen connected with the institution. Hon. Morton McMichael presided. Prof. Lesley presented briefly, but clearly, the good work done and doing by the Academic and Scientific Departments. Rev. Dr. Beadle, on the part of the Board of Trustees, made a singularly forcible and telling speech in vindication of the broad, catholic basis upon which the University is now placed. He was followed by Prof. D. Hayes Agnew and Dr. William Pepper, who presented more prominently the present position of the Medical Department, and the urgent need of a further legislative appropriation to insure the completion of the new Hospital Building. The closing remarks were made by Hon. Mr. Chalfant, of the State Senate, assuring the audience of his warm sympathy with this latter project. Our readers may remember that the last Legislature appropriated $100,000 towards the erection of

the University Hospital, dependent upon the subscription of $250,000, which has since been obtained and the appropriation secured. The plans which have been adopted for the building call for an expenditure of over $200,000; and application has now been made for a second legislative grant of $100,000 contingent upon the subscription of an equal additional sum.

We learn that the prospects for securing both this appropriation, and that asked for by the Trustees of the Jefferson College for a similar purpose, are encouraging. It is our earnest hope that they may both succeed, and thus enable the two schools to provide the enlarged clinical facilities for their students which are so much needed in this city at present.

A NEW periodical, the *Medical Record*, has made its appearance in London. We presume the British medical mind will be undisturbed by the fact that the *Medical Record* of New York is in its seventh volume. And yet we do remember the howl that arose when our modest enterprise was begun, under the title *The Medical Times*, because *The Medical Times and Gazette* was already prosperously established. Either our action was innocent, or this "adoption" of the entire title of an existing journal is a very flagrant violation of the proprieties.

AN enterprising publisher in London has begun the issue of a series of photographic portraits of eminent medical men, now living, with biographical sketches, said to be revised by the subjects themselves. But the style of the sketches is so highly laudatory that Sir Thomas Watson has felt called upon to disclaim having either prepared or revised the one relating to him; and a similar denial has been made on behalf of Sir William Fergusson.

PRIZE.—The Venetian Institute of Science, Literature, and Art will, says *Le Mouvement Médical*, award, in 1874, a valuable medal to the best work on the following topic: To show the advantages to medical science, and especially to physiology and pathology, of the modern discoveries in physics and chemistry; with a retrospective summary of the systems of medicine which have prevailed in the past.

NEW JOURNAL.—The same periodical mentions the receipt of numbers of a journal entitled the *Gazette Médicale de Bordeaux*, issued on the 5th and 20th of every month, sixteen pages octavo. The editor-in-chief is M. Fleury.

STILL ANOTHER.—From the same source we learn that a new obstetrical and gynæcological journal has appeared in Paris, entitled the *Gazette de Joulin*. "This title," it is said, "adopted to prevent confusion with any other similar publication, shows sufficiently that the editor is willing to assume the entire responsibility of his work."

MR. CARDEN, of Worcester, England, who died lately, had much to do with the restoration to favor of the operation of amputation at the knee.

M. CYON, who recently received the honors of the French Institute for his discoveries in regard to the nervous system of the heart, has been nominated professor of physiology in the Académie Médico-Chirurgicale at St. Petersburg.

IT is stated by telegraph that the French government, without stating its reasons for doing so, has issued an order directing the closing of the medical school at Montpellier.

THE death of M. Dubois (d'Amiens), perpetual secretary of the Académie de Médecine, is announced.

M. PIERRE CH. HUGUIER, of Paris, died on the 12th of January, aged 68 years.

MORTALITY OF PHILADELPHIA.—The interments reported at the Health Office for the week ending February 8, 1873, were 335; 195 adults, and 140 minors. 11 were of bodies brought from the country; making the mortality of the city 324. Among the causes of death were:

Consumption of the Lungs	62
Other Diseases of the Respiratory Organs	57
Diseases of the Circulatory Apparatus	17
Diseases of the Brain and Nervous System	67
Diseases of the Digestive Apparatus	15
Zymotic Diseases (2 from Smallpox)	27
Typhoid Fever	2
Casualties	8
Exposure	1
Murder	1
Suicide	1
Cancer	6
Debility (including "Inanition" and "Marasmus")	24
Still-born	12
Old Age	10

(The interments reported for the week ending February 10, 1872, were 500.)

THE meteorological record kept at the Pennsylvania Hospital was as follows:

	THERMOMETER.		BAROMETER.
	Max.	Min.	(2 P.M.)
Feb. 2	22.0°	14.0°	30.53 in.
" 3	36.0	17.5	30.17 in. (Rain.)
" 4	47.0	36.0	29.85 in.
" 5	40.0	32.0	30.33 in.
" 6	45.0	30.0	30.30 in.
" 7	40.0	36.0	29.84 in. (Rain.)
" 8	44.0	35.0	29.88 in.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY, FROM JANUARY 28, 1873, TO FEBRUARY 3, 1873, INCLUSIVE.

DE WITT, CALVIN, ASSISTANT-SURGEON.—To accompany Troop "K," 1st Cavalry, from Reno, Nevada, to Camp Bidwell, California, and, on arrival, report to the Commanding Officer of that post for duty at Camp Bidwell, or in the field. S. O. 12, Department of California, January 20, 1873.

CAMPBELL, A. B., ASSISTANT-SURGEON.—Assigned to temporary duty at Chicago, Illinois, to examine recruits. S. O. 21, War Department, A. G. O., January 25, 1873.